North Central London Integrated Care System

Joint Health Overview and Scrutiny Committee

NCL Community and Mental Health Core Offer

6th February 2023

Contents

North Central London Integrated Care System

North Central London Integrated Care System

Introduction and overview of the programme

Executive summary

North Central London Integrated Care System

Context

- As a new integrated care system (ICS), we must quickly take action to improve population health, individual patient outcomes and access and experience of care. We must also ensure our services are productive and offer value for money. There is a pressing need to enhance our local care offer and develop teams able to provide proactive and reactive care to all communities in north central London (NCL).
- NHS North Central London Integrated Care Board (NCL ICB) commenced a collaborative review of NHS community and mental health services 18 months ago. The aims of the review are to ensure there is an equitable service available across NCL which promotes out of hospital care and prevention, improving outcomes for residents and reducing the pressure on acute services. The stages of the review have included a Case for Change (Baseline Review) followed by the articulation of a co-produced "core offer" – i.e. the level of service every resident in NCL should expect.
- This work has engaged partners from all five boroughs. Both reviews have considered how we work most effectively at a system, place and neighbourhood level to improve outcomes. The "core offer" will support equitable access for all patients across NCL and support NCL to deliver its vision for integrated care and respond to major national reviews such as the Fuller Review.
- The total investment required for mental health is £25.1m; for community services it is £57.7m. We expect this investment to be implemented over a 5 year timeline. This investment requirement will be met through a combination of national funding (System Development Funding, Mental Health Investment Standard, Virtual Ward), ICB funding, system savings and productivity/efficiency requirements for providers. This will involve providers doing more within their current financial envelope and reconfigure how current resources are used to deliver more efficient models of care. The total investment level and allocation by provider was based on analysis of activity and benchmarking of provider productivity.

Objectives of this Joint Health Overview and Scrutiny Committee Paper

1. **Provide an overview and update on the progress of the community and mental health service reviews;**
2. **Demonstrate how co-design and co-production have been embedded in the design and delivery of the core offers;**
3. **Outline the benefits that implementing the core offers will bring for citizens, including for population health improvement; and**
4. **Describe how fragmentation in child and adolescent mental health services has been addressed, and how services join up to support young people transitioning from child to adult in community mental health services.**

There is a powerful case for changing community health and mental health services

North Central London Integrated Care System

Inequalities

There are stark inequalities in health needs and outcomes across NCL

Enfield has over twice the prevalence of diabetes as Camden; but half the diabetes resource

18% of people on the NCL mental health services caseload are Black/Black British, however, Black/Black British people accounted for 27% of NCL mental health inpatient admissions in 2019/20.

Provision

There is significant inequity, variation and gaps in service provision depending on where you live and this is not aligned to need

20% of children referred to mental health services in Islington wait over 18 weeks from referral to their first contact with services, compared to 1.2% of children in Barnet and 1.6% of children in Camden

Access

The way you access services and how long you wait is also dependent on where you live

Much of our mental health services are geared to a crisis response. In 2020/21, the former North Central London sustainability and transformation plan (STP) had the highest rate of detentions under the Mental Health Act per weighted population of STPs in England.

Spend

Different amounts are spent per head in different boroughs and this does not correlate with need

In Haringey £98 per head is spent on community health services vs. £192 per head in Islington. This results in less capacity in core services, meaning community health services would struggle to be full participants in population health improvement work.

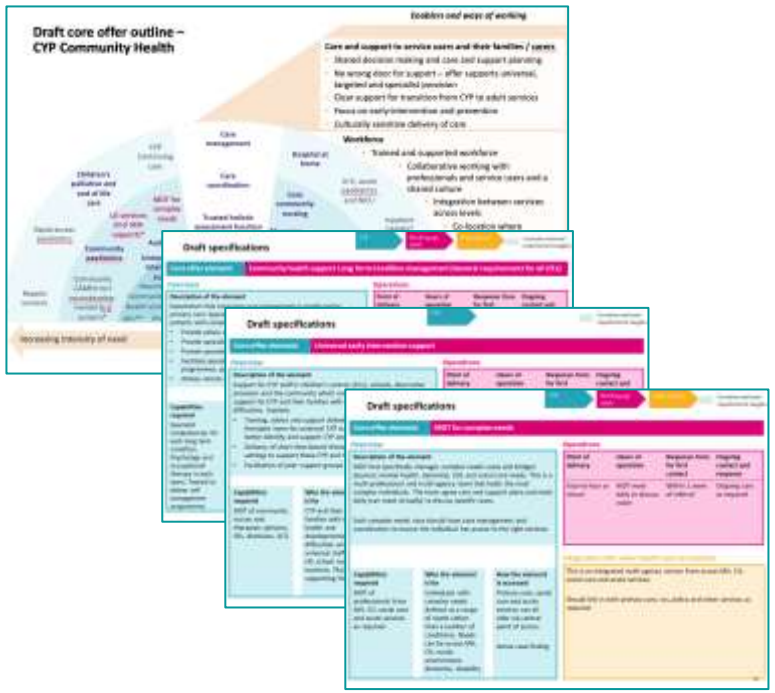
Service user/resident feedback

Services are difficult to navigate, and require servicer users to repeat their stories

Feedback from residents via our Resident Reference Group notes the distress caused by constant repetition of histories and stressed the need for shared records.

To respond to the case for change a core offer has been agreed which specifies what services should be available to everyone in NCL

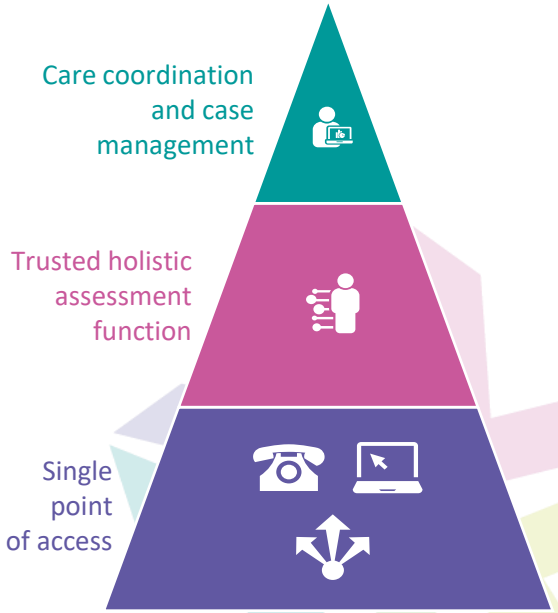
The purpose of the core offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL residents of the support they can expect to have access to regardless of their borough of residence.



Each core offer outline provides a description of the care function for the services and lays out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.

- Operating hours and out of hours provision
- Integration between the care function and other services and agencies
- Access to the care function and criteria
- Response time for first contact and ongoing contacts (in line with national guidance)
- Point of delivery (e.g.. in person, virtual)
- Workforce capabilities required
- Description of the service, including requirements to meet best practice guidance

Each outline also contains a set of coordinating functions which links service providers, ensuring effective communication, preventing duplication of services, identifying gaps in care, and assuring better health outcomes.



The journey so far for community and mental health service reviews has involved partners from across NCL

North Central London Integrated Care System

Start of review

March 21

Agreement was reached for a strategic review of Community Health Services and a case for change was created

Mental Health

May 21

A parallel review of Mental Health Services has been conducted concurrently based on a case for change

Design co-production

May - July 21

Co-developed case for change, service offer, inequalities identification, gap analysis against Borough, through interviews, surveys and workshops with a focus on Local Authority

Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

Core Offer

July 21

The purpose of the Core Offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence

Gap analysis

August 21

A gap analysis was conducted by Borough colleagues against the Core Offer

Investment principles and KLOEs for prioritisation

April – May 22

Investment priorities and KLOEs agreed at CH and MH programme Boards respectively

Provider collaboration

May 22

Areas for provider collaboration have been agreed to improve care and support financial sustainability

Provider completion of PIDs for collaborative projects

July – August 22

Benefits realisation and financial impact to be articulated for each project

Agree investment priorities for Y1 and profile multi-year investment plan

June 22

Programme Board agreed investment priorities based on gap analysis and correlation with investment and programme principles. NCL System Management Board (CEO level) endorsed approach

Implementation workshops

July – September 22

Borough Implementation workshops with place based partners in each borough

Sign off at ICB Members Board of multi-year investment plan

September 22

Following system wide discussions during June – August 2022

23/24 priority setting

December 22 – ONGOING

Borough engagement to update gap analysis and co-design investment priorities

Local delivery of Y1 initiatives

October 22 – ONGOING

Investment has been mobilised and delivery tracked

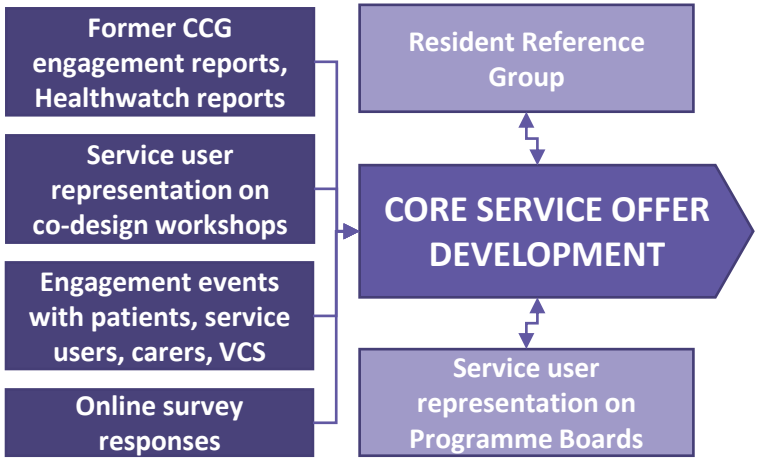
Co-production and co-design has been a central principle

North Central London Integrated Care System

Overview of principles and approach

- Engagement with patients, service users, carers and residents and understanding their experience of services has been **crucial for the community health services and mental health services strategic reviews**. The views and feedback we have received throughout this programme of work has been invaluable in helping to develop the core service offers.
- We engaged with a wide range of **service users, patients and carers groups, as well as voluntary and community sector organisations** across north central London to ensure the service user and carer voice is central to our work, reflecting the diversity of the communities we serve, and embedded throughout each phase of the review programme. We recognise the **valuable insight that people with lived experience bring to service transformation and commissioning** and the important part this insight plays in contributing to our aim to improve the overall health and wellbeing of the people and communities living in north central London.
- Co-production will mean that we commission and design services that **accurately reflect the needs of those using them which then leads to better health outcomes**. It is also a **cost-effective** way of making sure we spend vital NHS money in the right way first time.

Model of co-design



Community CYP

- Involving families in shaping solutions: Parents worked alongside professionals in our CYP Autism / ADHD transformation group, helping shape recommendations about how to improve provision.
- Their input has informed a new NCL wide objective to moving towards more needs-led care less dependent on a diagnosis

Barnet, Enfield and Haringey Mental Health Trust (BEH) CAMHs

- Appointed a co-production lead to fully co-produce transformation programme and establish service user groups across the tri borough services. To support the development and access to experts by experience, local communities groups and a range of VCS that can support co-production.
- Enfield Borough completed a research project and engagement with CYP, parents/carers and professionals with approximately 72 participants and held an event in December to share the outcome and create key links of engagement.
- BEH CAMHs developing a co-production group to support with ensuring the voice and experience of user is at the heart of transformation and co-design. This will work with NCL's CYP Mental Health Coproduction Steering Group, a group with parent representation seeking to embed coproduction in CYP MH work

Open Door Haringey

We have established patient and user groups, we have a pool of experts by experience, and we engage with a broad range of VCS who sit alongside our clinical leadership in facilitated service design and review groups. Young people were involved in the design of our website and contributed their experiences of Open Door. Open Door has people with lived experience working within all levels of the organisation:

"Open Door were able to demonstrate that children, young people and their parents were at the heart of the service vision…We heard of a strong ethos and culture of needs led and outcome-based care…and young people's participation in service design and research…There was a clear vision and sense of strategic direction led by leaders with extensive clinical knowledge and expertise…" Local commissioners were advised to "secure the longer-term funding certainty of Open Door"

- NHS England Mental Health System Improvement Team, 2019/20

We have been responsive to citizen engagement

North Central London Integrated Care System

You said…	We did…
Need to improve access to services and reduce waiting times	Core offer for each function features response times, including for first and ongoing contact e.g. investing £1.7m into additional autism/Attention-deficit hyperactivity disorder (ADHD) assessment capacity for children to reduce waiting times.
Reduce the number of 'hand offs'' between organisations through better use of technology so that people avoid having to frequently repeat their details/stories.	Develop coordinating functions through a series of workshops on early intervention, incorporating national guidance. This will ensure that those with complex needs can have a single assessment and holistic treatment plan in place.
Services need to improve their communications with patients, such as changes to appointments or cancellations and be more responsive to patient queries.	Core offer proposes more services with direct access, reducing the need for referral by primary care.
Digital services welcomed by some, but concern that digital exclusion for others could lead to even greater health inequalities. Services must be responsive to the individual's preference.	Roll out of 'virtual wards' underway which allow patients to be cared for in the comfort of their own home with the use of technology to monitor their health remotely where they and their families agree this is in their best interests.
A need for more holistic, person-centred care with consideration given to other factors that can impact health. Residents indicated wanting greater involvement in decisions about their care.	The agreed core offer supports the personalisation agenda, with more care planning, case management and enhanced patient led decision making, including proactive support for those with long term conditions e.g. Islington SEMH front door.
Early transition planning needed to support children and young people to adult services, especially in relation to mental health services.	We have worked with young adults to develop a new young adults mental health strategy building on nationally recognised good practice in our region.
Services must be culturally competent and providers need to work with their communities to recruit more local people and use their experience and knowledge to work more effectively with diverse local populations.	Provision of crisis prevention houses, safe havens / crisis cafes in each borough for those at risk of mental health crisis.
A need for greater focus on early intervention and prevention.	Our Community and Mental Health Service Review programmes have at their heart a commitment to shifting resource from reactive care to earlier intervention. We have invested an additional £7m in community services and £11m in mental health community provision from 22/23 onwards.

Local priorities have been incorporated into core offer investment areas through ongoing engagement

North Central London Integrated Care System

1. Update borough gap analysis

- **Refresh of the gap analysis by each Borough Integrated Care Board (ICB) and provider lead (if needed) to determine current provision against the core offer**

2. Collate borough investment recommendations

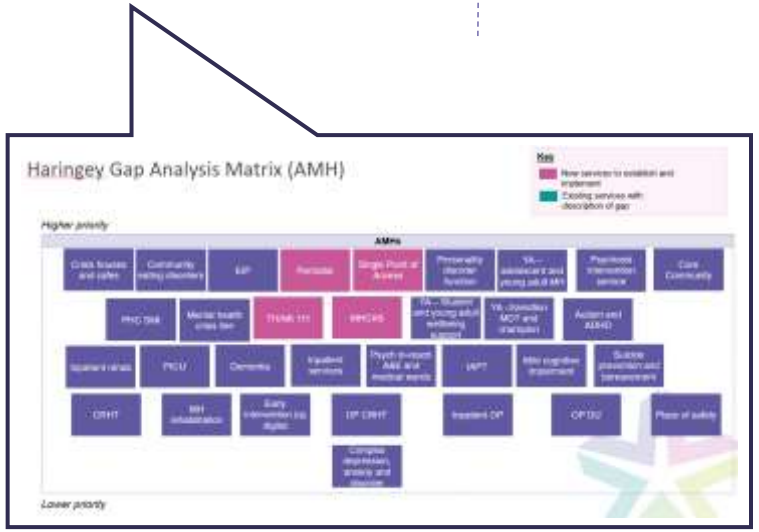
- Refresh of the gap analysis by each Borough ICB and provider lead (if needed) to **determine current provision against the core offer**
- Collate long list of **potential investment areas** (up to 5 per Borough based on £ and programme principles)
- **Cost items on long list** (within a range)

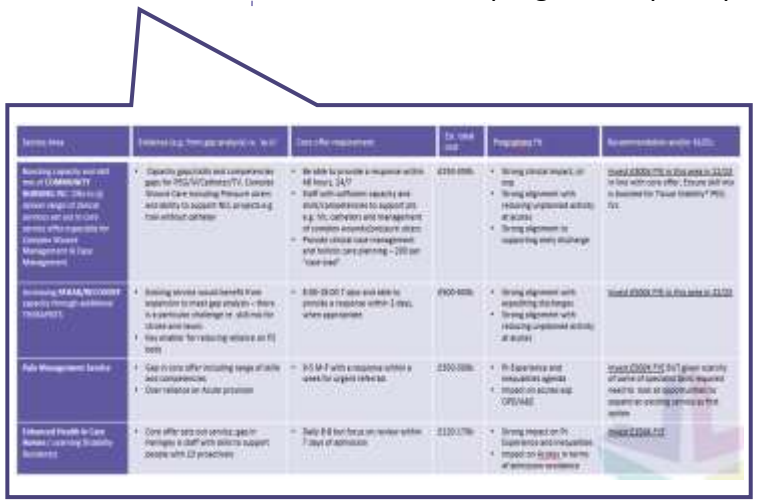
3. Borough partnership engagement

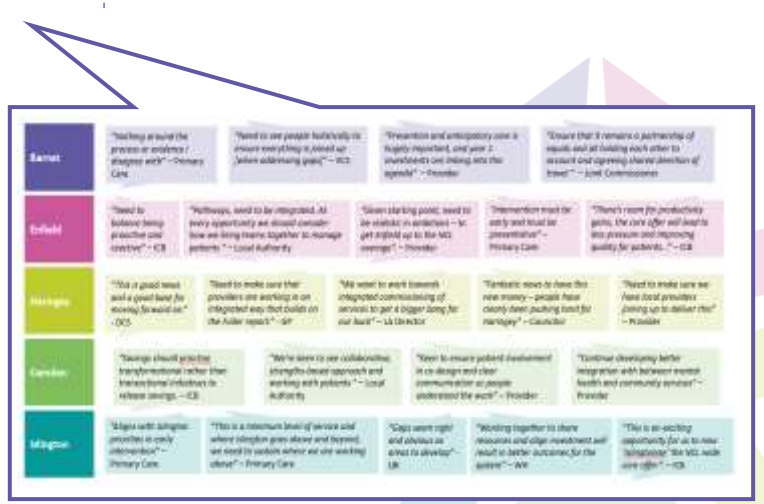
- **Series of Borough workshops**, including community and mental health providers, acute providers, voluntary sector, primary care, local authorities, service users and their families/ carers
- **Validate the gap analysis**, and prioritise investment areas based on financial and programme principles

4. Tracking borough outcomes

- The population outcomes as a result of the core offer are being tracked through **outcomes framework dashboards** for both community and mental health at an ICS and Borough level which will be reported and used to support decision-making
- Part of these frameworks will include **equity ratios on ethnicity and deprivation**







Place-based Borough partnerships have a key role in delivering the core offer and supporting integration

North Central London Integrated Care System

An NCL ICB system level Programme Team supports the Programme Boards, Implementation Steering Groups and Chief Finance Officer led Finance Subgroups to provide governance to "core offer" delivery, as well as benefits realisation and opportunities for collaboration. The core offers are being delivered through place-based Borough Partnerships.

Design Requirement:	Detail:	Enabling local delivery:
Co-design of services and vision with Borough partnerships	Strong and ongoing engagement of Borough partnerships in the identification of local gaps against the core offer and design and prioritisation of investment recommendations to address these. This includes partners across Primary Care, Local Authority and VCS.	**Ongoing local engagement and co-design.**
Implementation of "core offer" to report into place	Clear lines of sight into decision-making and risk-management processes with appropriate balance between central coordination of the "core offer" and local ownership and utilization of existing governance and reporting infrastructure.	**Prioritisation of local "core offer" delivery within local governance forums**
Place based transformation capacity	Many initiatives (from anticipatory care to community transformation in mental health) need to be delivered at place/neighbourhood level in order that integration benefits are realised. Borough delivery resource facilitates delivery between system partners.	**Dedicated transformation capacity working in place**
Differential place based capacity dependent on degree of change	Every borough needs some 'base capacity' but those boroughs which have the most change to make should receive additional resource during this first phase of the programme and some have been provided with programme resources to recruit fixed-term support focusing on Borough delivery.	**Boosted community transformation capacity for Haringey and Enfield**

North Central London Integrated Care System

Mental Health Core Offer

The Mental Health Core Offer will improve access, quality, equity and for resident and improve our workforce

North Central London Integrated Care System

Overview of mental health core offer:

Core offer outlines provide a summary of care functions and services that are part of the core offer for the below age segments. The outlines also show complementary care functions that should be linked in with the core offer and a set of enablers.

Children and young people

Young adults

Working age adults

Older people

Benefits of mental health core offer:

Access

- Standardised service provision
- Extended opening hours and access to out of hours services – **more convenient access to services**
- **Standardised waiting times** (e.g., to first contact and follow up)
- **Simplified referrals** processes through a central point of access

Quality

- Focused on **prevention** and **early intervention**
- Extended opening hours and **enhanced response times** for care functions that help service users stay well and **minimise need for hospitalisation** (e.g., crisis services)
- **Bespoke services for young adults** in line with the Minding the Gap model
- **Enhanced dementia and mild cognitive impairment functions**
- **Provide better in-reach to inpatients** (Tier 4) to facilitate early discharge

Equity and equality

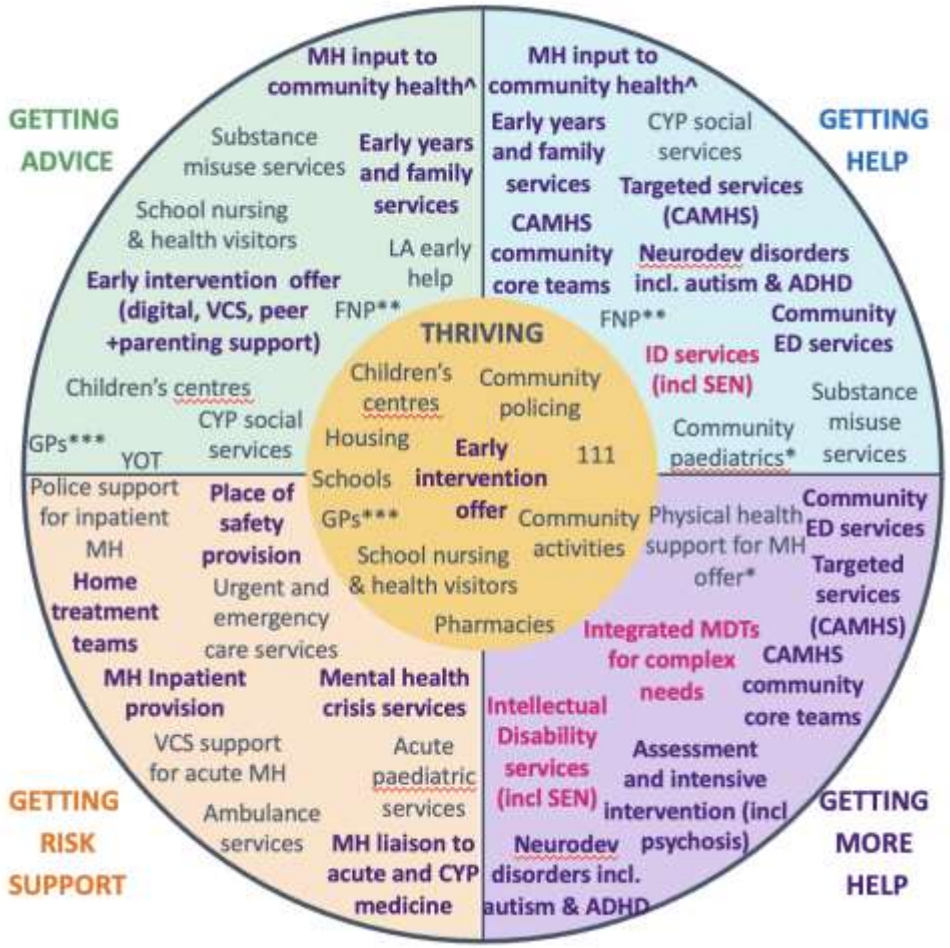
- Core offer aims to deliver a **consistent and standardised offer** for community services. Core offer includes links with other agencies and support that **focus on wider determinants of health**
- **Enhanced Improving Access to Psychological Therapies (IAPT) and crisis services** to reach BAME populations

Workforce

- Core offer will **support staff to operate at the top of their license, work collaboratively and flexibly** across organisational boundaries and this should **improve staff satisfaction levels**
- Ways of working will be impacted by having increased **joint working** to deliver place-based care **co-location** where appropriate, and **joint training**

The core offer outline supports the different needs groupings of CYP in line with THRIVE framework

North Central London Integrated Care System



Enablers and ways of working

Care and support to service users and their families / carers

- Shared decision making and care and support planning
- No wrong door for support
- Services sensitive to cultural and other demographic factors that impact on how individuals prefer to access care
- Focus on early-intervention to reduce crisis presentations

Workforce

- Trained and supported workforce
- Collaborative working with professionals and service users and a shared culture
- Integration between services across levels
- Co-location where appropriate

Digital

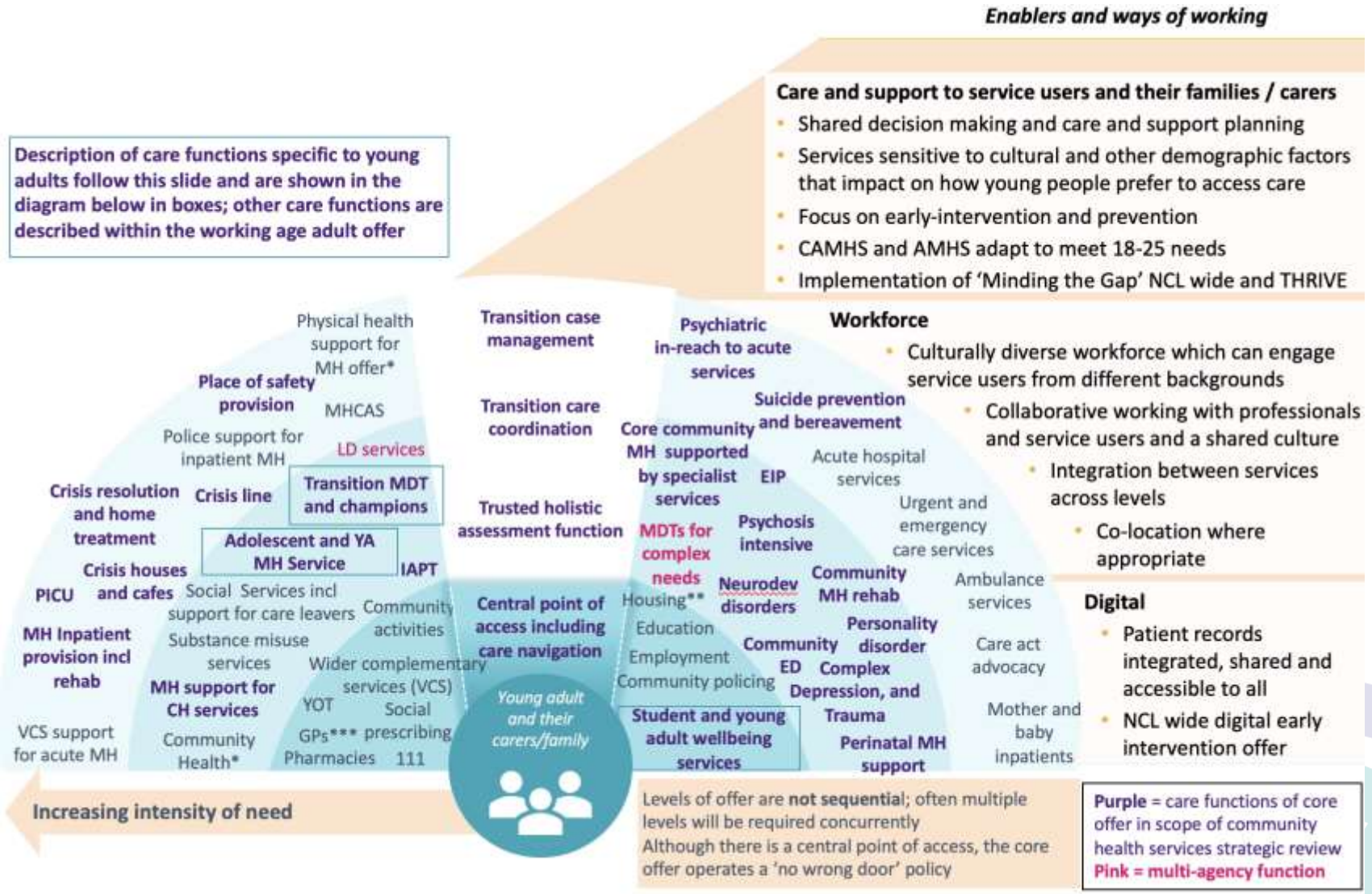
- Patient records integrated, shared and accessible to all
- NCL wide digital early intervention offer

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency care function

The coordinating functions (central point of access, trusted holistic assessment, & care coordination / case management) help to navigate and deliver integrated care through the THRIVE framework

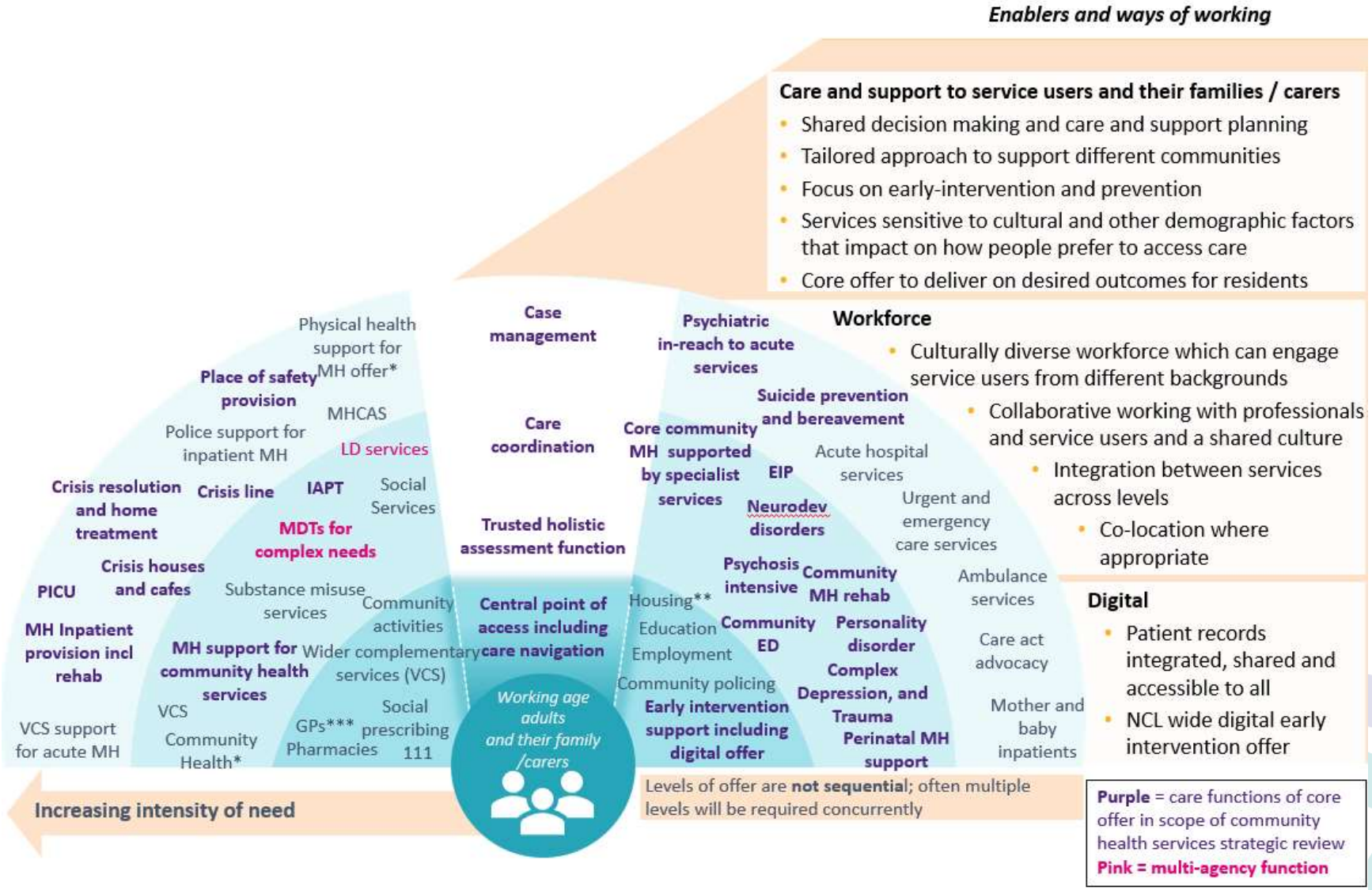
Core Offer outline – Young adults (18-25) Mental Health

North Central London Integrated Care System



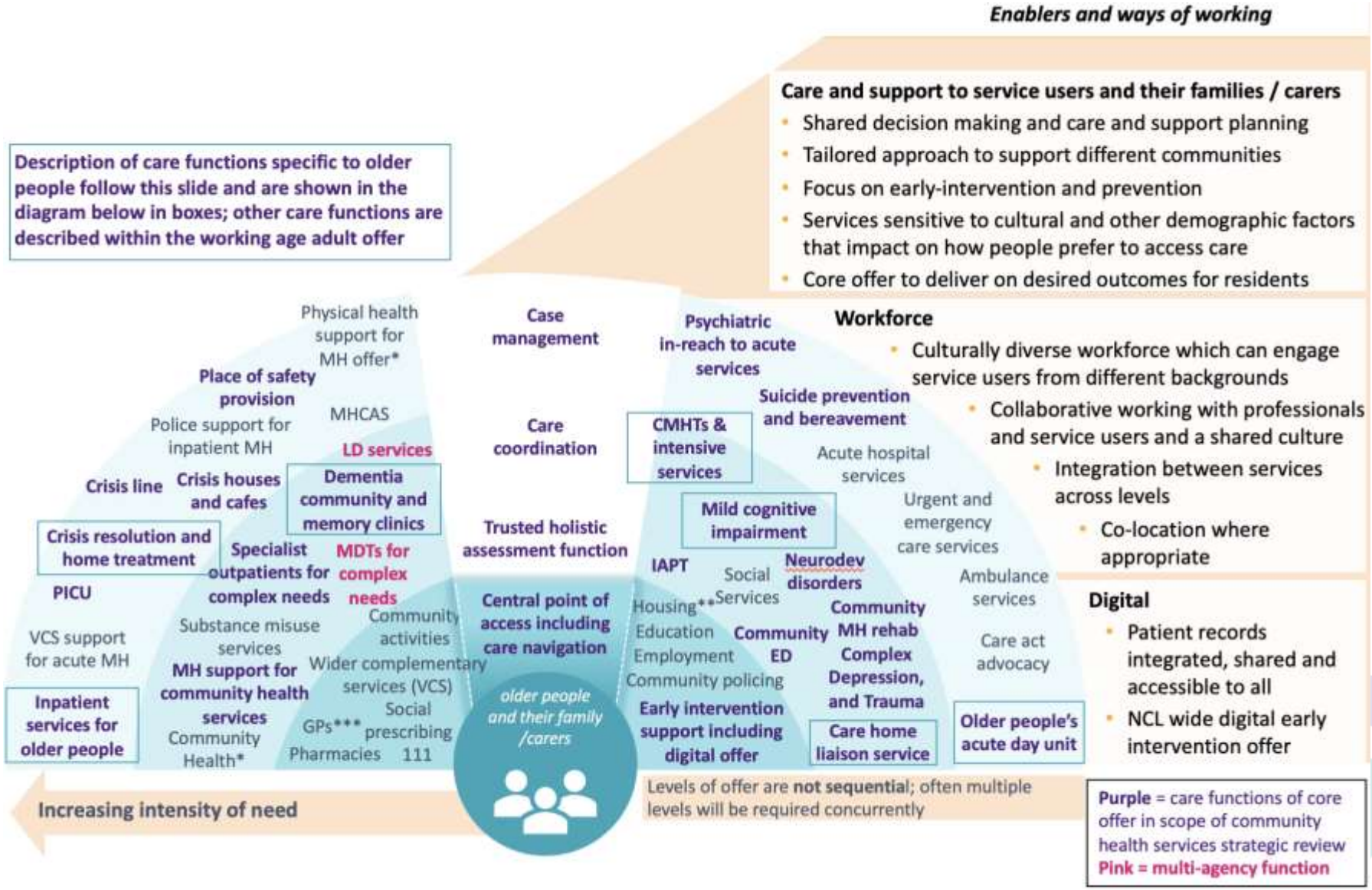
Core Offer outline – Working age adults Mental Health

North Central London Integrated Care System



Core Offer outline – Older people Mental Health

North Central London Integrated Care System

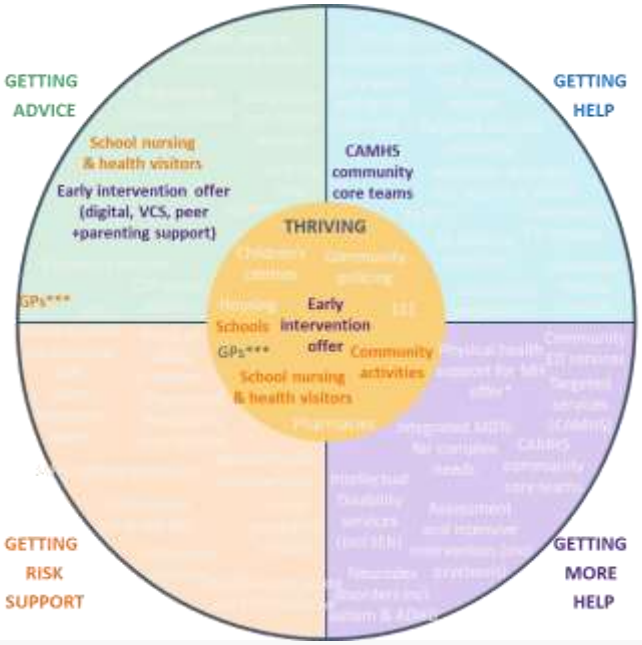


How Freya's care will be experienced differently as a result of the Community Core Offer

North Central London Integrated Care System

Child with complex needs

Freya is a white 14-year-old teenager whose academic performance at school has been deteriorating. She appears withdrawn and tired in class. She has stopped playing in the band she was formerly a member of. She lives in cramped accommodation with not much money at home, her parents are separating, and she is being bullied at school.



Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Freya's school tutor (who has received training under the universal mental health offer) is concerned and has a 1-1 catchup with Freya and asks the local mental health in schools team to see her via the central point of access. The school tutor also provides support with the bullying in line with the school's whole school approach. Freya is seen within two weeks by a mental health in schools practitioner, has a full holistic assessment and is diagnosed with mild anxiety and depression. She is signposted (THRIVE getting advice) to some self-help materials and information regarding sleep hygiene and anxiety management. She is encouraged to engage with the NCL online digital mental health counselling and peer support offer. Freya's parents are both engaged with group-based parenting support. She is also encouraged to sign up to a local resilience building music activity based at local youth club run by the VCS. Freya's mood and anxiety improve and her grades start to improve. Her GP is kept updated via the digital integrated care record.

Subsequently however, her mood does worsen, she starts withdrawing again from activities she previously enjoyed and reports not being able to get to sleep at night. She reports this to the school nurse when having a routine vaccination. The school nurse gets in touch with the mental health in schools practitioner who reviews Freya again. She assesses that Freya's anxiety and depression has worsened and arranges for Freya to be reviewed together with her parents by the core CAMHS community team within two weeks. They co-produce a treatment plan with Freya and her parents together with the school mental health practitioner. This involves a course of cognitive behavioural therapy alongside the ongoing digital support and the support for her parents. Freya's mood improves and she is able to return to her normal level of functioning.

Resident impacts: Children / Young people mental health

North Central London Integrated Care System

What did the service historically look and feel like?

- **CYP Home Treatment Team (HTT):** There isn't a CYP HTT across NCL, it is an NHS Long Term Plan ambition. The service will enable CYP in mental health crisis to have equitable access to risk support in order to prevent escalation, and to access intensive community treatment as an alternative to Tier 4 admission. The evidence base for treating children and families in their own homes is strong.
- **Dialectical Behaviour Therapy Service (DBT):** DBT is a mindfulness and acceptance-based cognitive-behavioural therapy adapted for treating people with severe complex, hard-to-treat multi-diagnostic conditions, in particular Borderline Personality Disorder (BPD) or Emerging Emotionally Unstable Personality Disorder (EUPD). Historically, there hasn't been a DBT in NCL.
- **Eating Disorder:** Not meeting the 95% target for urgent cases (<1 week) and routine cases (<4 weeks). Delayed mobilisation of the Disordered Eating and Avoidant Restrictive Food Intake Disorder (ARFID) support linked to NCL community CAMHS teams.
- **CYP Recovery and Transformation:** There is variation in service access and pandemic exacerbated waiting times. Highest total waiters is Barnet = 26.1% (863), Islington = 24% (792), Enfield 23.3% (767). Islington have the highest waiters per 1000 CYP weighted population (19/1000). Haringey has the highest mental health needs for children and young people overall, as well as high presentation in A&E for mental health reasons.
- **Young Adults:** There are long waiting lists, with limited support for those waiting and no NCL boroughs are 100% NICE compliant. There is variation in post diagnostic parent support and peer support. Insufficient capacity within transition worker teams, and limited outreach to those that are not presenting to services e.g. NEET young adults, Looked After CYP, young adults with a dual diagnosis.

With the core offer, what will the service look and feel like?

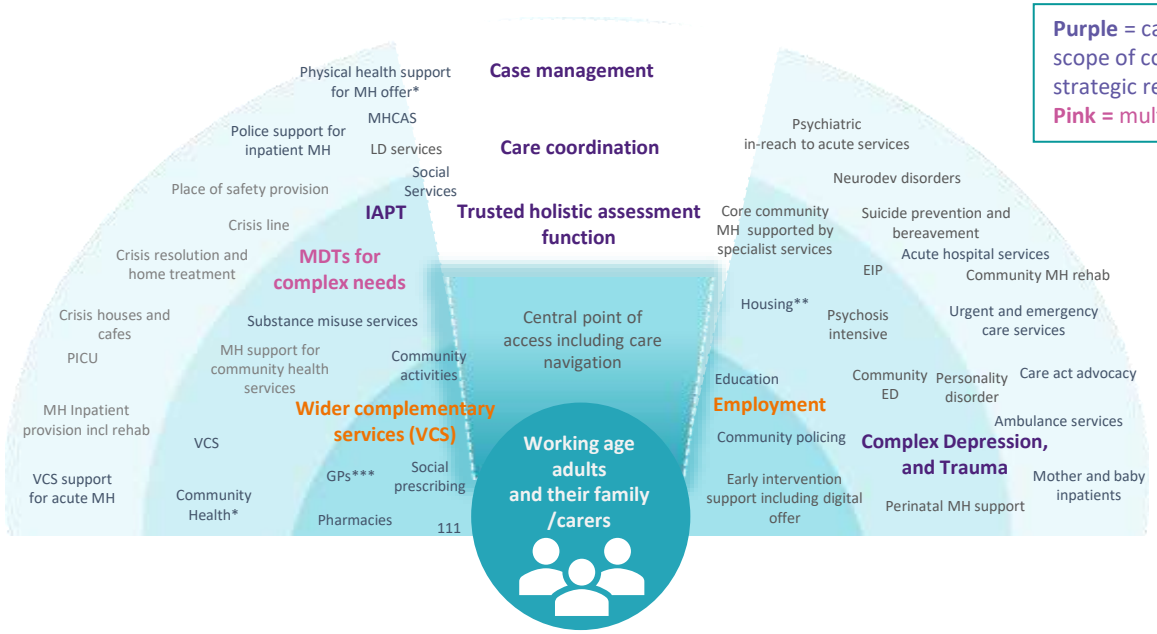
- **CYP Home Treatment Team (HTT):** Barnet pilot underway in 22/23, where admission rates are highest. Based on the evaluation NCL will roll out to the other boroughs in 23/24. The Barnet HTT service provides intensive home based support for CYP Aged 12-18 years at risk of admission to an inpatient unit. Operating 09:00-20:00 hrs, 7 days a week.
- **Dialectical Behaviour Therapy Service (DBT):** The 22/23 investment into the NCL DBT services has provided a local service to replace the need to refer CYP to services in South London and Hertfordshire. This will improve patient experience and improve adherence to therapy and reduce the number of missed appointments.
- **Eating Disorder (ED):** Investment made into specialist and community ED services. Waiting times have reduced from 10 weeks to 6 weeks. Community ED service set up, which provides holistic assessment and co-production of care plans for CYP and families. Early identification and support, from specialist trained staff embedded within community CAMHS teams that provide advice, interventions for ARFID and other complex eating disorders. As well as support and training to other mental health and wider community services.
- **CYP Recovery and Transformation:** CAMHs provide integrated support into Looked After CYP, social care, youth offending and Early Help teams. CYP receive holistic assessments in conjunction with the care practitioners and plans are co-developed in line with THRIVE principles of holistic support. There is increased provision in Mental Health Support in Schools.
- **Young Adults:** Increased investment has increased the number of workers recruited, which has helped to reduce variation and equality of provision across the five boroughs. Young Adults Strategy and model of care has been co-produced and continued work is needed to embed the aspirations of the strategy.

How Tracey's care will be experienced differently as a result of the Mental Health Core Offer

North Central London Integrated Care System

Young adult with mental health needs

Tracy has used mental health services for most of her life. She was abused as a child, has been in a violent relationship and has had periods of depression – now she is using that experience to help others.



Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function

What care will look like through the core offer

Tracy's story is truly inspiring. About 18 months ago, she was given support by The Network, a secondary care service created by Barnet Council with Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). That changed her life and gave her mental and emotional stability and a new focus.

Last year, she joined BEH as a Peer Engagement Practitioner with our Barnet North Core Community Mental Health Team; she is employed by the charity Meridian Wellbeing, working in partnership with BEH, and currently supports 24 service users, with weekly appointments on the phone or face-to-face.

"I tell them that they can get better, because if I can do it then anybody can. It takes time and work but after a few weeks they feel the benefit."

She introduces people to activities and services that will help them to socialise, overcoming isolation and mixing with others who have shared experiences. She encourages people to join wellbeing sessions, including some at the Meritage Centre, in Hendon, where there is a Wellbeing Café, run by Meridian Wellbeing. Tracy works as part of a multi-disciplinary team, alongside psychologists, social prescribers, community engagement workers and other specialists. They work together to achieve the best outcomes for each service user, who is consulted at every step of the recovery journey.

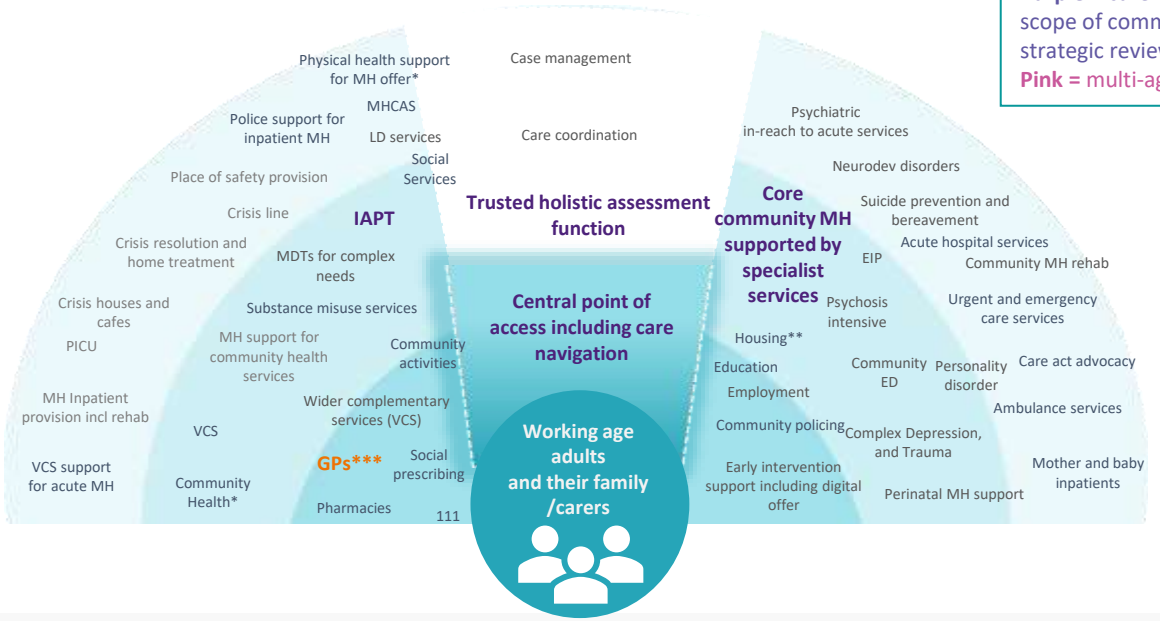
How Ludumo's care will be experienced differently as a result of the Mental Health Core Offer

North Central London Integrated Care System

Young adult with mental health needs

The pandemic had a profound effect on **Ludumo**; she had received help with her mental health in the past and during the lockdowns she recognised the signs of starting to feel down and needed support.

Purple = care functions of core offer in scope of community health services strategic review
Pink = multi-agency function



What care will look like through the core offer

Ludumo said: "I was starting to feel anxious again and could tell that I was generally falling into depression and I wanted some help with that. I knew the signs and I knew it was best to get help quickly."

Ludumo, who has three children and also supports her mother, who has mobility problems, contacted her GP. "The GP referred me to the Mental Health Core Team and someone got in touch. We had a couple of online video calls with an assessment and then I went and met her at the GP clinic."

"I have found it really helpful. It is so much easier to open up and talk about your feelings to someone who you don't know and who isn't judging you. I was offered advice and support about lots of things. I was given lots of information about activities near where I live, and encouraged to go along and take part. Some of them are things I can do with the kids and that's really good because it involves them and it's good to have things for them to do.

"After about six sessions I started feeling much more positive and able to cope. I think I will be ok now, but I also know to reach out again if I need more support. I have taken medication in the past but I didn't want to do that again, I think this support is much better than anti-depressants and has really helped me feel back on track."

Resident impacts: Adult Mental Health (1/2)

North Central London Integrated Care System

What did the service historically look and feel like?

- **Adult Community:** There are long waiting lists for secondary mental health services, and variation in Core Teams, secondary care services and pathways across the boroughs. There is insufficient capacity in ED services, especially within mild to moderate need and significant waiting lists in Personality Disorder services. For complex rehabilitation, there is variation in service across the boroughs.
- **Improving Access to Psychological Therapies (IAPT):** There is insufficient capacity within the service to achieve 22/23 NHS Long Term Plan access targets, including delivering IAPT services to young adults 16+ population, and to offer all people with a long term condition.
- **Mental Health Liaison Services (MHLS) and Mental Health Clinical Assessment Service (CAS):** There has been a historic challenge to meet Core 24 service standard in the north of NCL.
- **Crisis Houses and Crisis Cafes:** There is a gap in full provision of crisis house model in the north of NCL, equivalent of the Gold Standard Drayton Park model in the south. Camden and Islington NHS Foundation Trust (C&I) relocation of crisis houses before St Pancras development. Gap in the provision of a crisis café in Camden.

With the Core Offer, what will the service look and feel like?

- **Adult Community:** Largest investment area for mental health - Transformed Community Mental Health Services wrapped around primary care, integrated with social care and VCS for patients with a serious mental illness. Roll out of new transformed community core teams to reach 100% of primary care networks (PCNs) in 22/23. Transformed secondary care models including; Personality Disorder, Eating Disorders, Complex Rehab, Early Intervention in Psychosis.
- **IAPT:** Holistic assessment and subsequent delivery of National Institute for Health and Care Excellence (NICE) approved therapeutic interventions including cognitive behavioural therapy (CBT) for depression, anxiety and other common mental health disorders. Available from NHS and VCS organisations, both face to face and virtually 7 days a week, available in 20+ languages with psychological interventions for people with long term conditions. If needed, patients are supported to access support from local community mental health. The number of people accessing the services are still challenged.
- **Mental Health Liaison Services and MH CAS:** The Core 24 service standard is now being consistently met across NCL. Patients receive a mental health assessment within 1 hour in A&E and 24 hours on the wards.
- **Crisis Houses and Crisis Cafes:** Investment made in the north crisis houses and Camden Cafe. The new model supports both step up (admission avoidance) and step down (early discharge) to help manage bed pressures in line with C&I Gold Standard. The Core Offer includes delivery of Haringey Canning Crescent development in 2023, and there is a Crisis Cafe open in each NCL borough.

Resident impacts: Adult Mental Health (2/2)

North Central London Integrated Care System

What did the service historically look and feel like?

- **NCL mental health crisis line / THINK 111:** No universal point of access for people experiencing mental health crisis, ensuring that anyone experiencing mental health crisis can call NHS 111 and have 24/7 access to the mental health support they need in the community. Integrated ICS-level Hub.
- **Adult Inpatients:** There are significant out of area placements with an NHS England recovery plan for NCL. There is significant length of stay in south and inequality in access across genders. NCL has no female long term inpatient high dependency rehabilitation beds. Capacity does not reflect the amount of supported accommodation per borough.
- **Perinatal:** This is a NHS England focus due to national underperformance. Insufficient NCL capacity to meet the needs of over 2,000 women accessing Perinatal services, equivalent to approx. 10% of births. There is a gap to meet the NHS Long Term Plan ambitions. Barnet and Enfield have lower levels of access than the other boroughs.
- **Suicide Prevention and Bereavement:** Further opportunities for expansion of population health interventions and services to support suicide prevention.

With the Core Offer, what will the service look and feel like?

- **NCL mental health crisis line / THINK 111:** Crisis Lines / THINK 111: Integration of the 2 crisis lines into one single point of access. Development of THINK 111 'press 2' for all 111 calls indicating they are in mental health crisis will be answered by trained mental health professionals within mental health trusts.
- **Adult Inpatients:** Mutual aid being provided between the trusts to share the bed provision. Establishment of Integrated Discharge Teams over the winter period to support the continued focus on reducing length of stay, timely discharge and flow. Complex rehab repatriation of those placed out of area developing a business case to understand opportunities and efficiencies if able to repatriate patients back into NCL.
- **Perinatal:** Increase access to evidence-based care for women with moderate-to-severe perinatal mental health difficulties and/or complex needs. Expanded the NCL maternal mental health 'Maple' pilot service across into Camden, Islington and Barnet offering equitable access. Working with emerging perinatal provider collaborative landscape.
- **Suicide Prevention and Bereavement:** Delivery of Wave 3 & 4 Suicide Prevention and Bereavement support. Achieving 72 hour follow-up inpatient target to reduce risk of suicide.

NCL ICS Young Adults (16-25) Programme

North Central London Integrated Care System

NCL ICS Young Adults (16-25) Programme Ambition

'For every young adult, aged 16-25 living, working or studying in north central London to enjoy good emotional wellbeing and mental health, whilst being able to easily access timely and good quality support when required.'

This programme aims to **improve young adults mental health outcomes** and experiences of mental health services, including **transitional services**, that are aligned to the THRIVE Framework; NCL Children and Young People Mental Health Transformation Plan; and the national NHS Long Term Plan priorities.

- In 2021 a **NCL mental health service review** led to the development of an identified **core service offer** with the aim to provide equity in provision across NCL whilst addressing inequalities.
- A new **NCL ICS Young Adults (16-25) strategy** has been produced which includes short term and long term aims to provide equitable, flexible, provision to meet local need with a focus on quality of care and patient experience, building on the current offer.
- The **NCL ICS steering group** has responsibility for overseeing the implementation of the strategy and produce recommendations for future investment for 23/24 and beyond.

NHSPowerPoint Presentation (nclhealthandcare.org.uk) Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24
NHS Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24

Young Adults Engagement & Co-production

North Central London Integrated Care System

Overview of mental health core offer:

The steering group will work closely with the following to **obtain feedback from young adults** on progress and listen to areas of good practice and areas requiring improvement;

- C&I and BEH Trust Boards
- Brandon Centre Ambassadors
- Minding the Gap service users
- Open Door service users
- Wider population cohorts by working in partnership with borough based community groups and services

Snapshot of Young People Feedback: Nov/Dec 2022:

What do you feel is the best way to engage with young people to obtain their views on mental health and emotional wellbeing services?

Childcare available for young parents to access support *– 21 year-old*

Flyers on services and text reminders about appointments *– 18 year-old*

Activities during therapy e.g. art *– 17 year-old*

Don't treat them like children- no rapid fire questions *– 16 year-old*

Feedback from current services:

Open Door are good with communicating …they get back to me, and puts me at ease. *– 21 year-old*

Moving around a lot in care means timely support is not always available. *– 21 year-old*

Counselling in the school building made it easy. Open Door is good as therapist is in contact with other professionals *– 17 year-old*

Didn't like online counselling. Face to face is more personal. *– 21 year-old*

NCL Mental Health Support for Young Adults

North Central London Integrated Care System

Overview of providers:

The **two lead NCL NHS providers supporting young adults with transition** and a core young adults service with adult mental health services are;

- Barnet, Enfield and Haringey (BEH) Mental Health NHS Trust
- Camden & Islington (C&I) NHS Foundation Trust

Key **community providers supporting young adults in mental health and emotional wellbeing** include;

- Open Door in Haringey
- The nationally recognised 'Minding the Gap' programme in Camden;
  - The Brandon Centre
  - The Hive (Catch-22)
- Social, Emotional and Mental Health (SEMH) services in Islington (16-25)
  - The Brandon Centre
  - Isledon Emotional Wellbeing Service
  - Youth Counselling and Substance Misuse and Alcohol Service
- All providers work in partnership with Children and Young People Mental Health services and all of the above are partners of the NLC ICS Young Adults (16-25) Steering Group

NCL best practice:

- **Suicide prevention**: Camden; Haringey; Islington
- **Emotional wellbeing/social prescribing**: SEMH Central Point of Access Islington
- **NCL wide 24/7 crisis line**
- **NCL Crisis hubs** and Out of Hours service
- ICS wide commitment to alignment with the **THRIVE Framework**
- New health and wellbeing programme designed to **support young black men aged 11-25**; Islington
- **Minding the Gap**: Camden

See next slide

Minding The Gap (Camden)

North Central London Integrated Care System

Overview of service:

Nationally recognised model of best practice aims to improve the mental health of vulnerable young people aged 16 to 24 and support their transition from children's into adult's services.

Developed in partnership with young people, it is an excellent example of integrated service delivery. Services include mental health support; sexual health; substance misuse; employment; personal development support and social activities.

Partner organisations:

Minding the Gap has three key elements:

1. A mental health transitions team in the Adult Mental Health team at C&I Foundation Trust, with bi-weekly multi-disciplinary team meetings for CYP with complex needs who need transitioning into adult services;
2. A counselling and psychotherapy service for young people who need mental health support but do not meet threshold for adult mental health services, provided in an accessible community venue by the Brandon Centre;
3. The Hive, a state-of-the-art youth operated by Catch 22 offering a holistic, integrated and wide-ranging health and wellbeing offer to young people.

A Young Person's Journey: 19-year-old-female Transition from CAMHS to Minding the Gap to Adult MH

North Central London Integrated Care System

Background

High levels of anxiety and depression; Under care of CAMHS psychiatrist for 2 years. Family did not attend appointments. She dropped out of education and training and rarely left the family home. There is a high level of deprivation, and social care involvement.

Minding the Gap Support

Weekly 1-1 home based sessions for six months followed by five months of family work with the young person and her mother. It was disclosed that there was history of significant intergenerational trauma and abuse. The young person's mother was supported to access her own mental health support.

Transition Panel

The Minding The Gap Transitions panel decided the young person should be offered psychotherapy with the Adolescent and Young Adults Service (AYAS) from the Tavistock and Portman.

Continued Adult MH Support

The young person is now engaging with the assessment process for the Tavistock and Portman Adolescent and Young Adults Service.

OUTCOME

The young person has also enrolled and has returned to college to continue their education.

Young Person's Journey: 21-year-old-female
Entering the mental health system for the first time

North Central London Integrated Care System

Background

Mixed heritage. Living with mother; very socially isolated; unemployed and not in education; Had a history of mental health difficulties. Due to family dynamics, and mistrust of services, had not accessed mental health support previously. Conflict and significant domestic abuse towards their mother.

Minding the Gap Support

They experienced suicidal ideation and accessed the NCL crisis team, after which she self-referred to the Hive. The Hive slowly built trust and over remote sessions completed an assessment. The assessment highlighted that she was suffering with a high level of social anxiety and depression.

Transition Panel

The Minding The Gap Transitions Panel recommended the Complex Depression Anxiety and Trauma Service (CDAT) as best placed to provide ongoing mental health support for them.

Ongoing Integrated Support

The Hive worked with Adult Mental Health Safeguarding, the police, and Adult Social Care. Information was provided by Minding the Gap to the Complex Depression, Anxiety and Trauma (CDAT) Service, provided by Camden & Islington NHS Foundation Trust, for them to engage with and support the young person safely.

Social, Emotional & Mental Health (SEMH) Central Point of Access & Community Services, Islington

North Central London Integrated Care System

Overview

- The social, emotional and mental health (SEMH) model was awarded 'commended' in the 2020 Health Service Journal Awards.
- Launched at the end of Sept 2019. It has been successfully integrated into Islington's Children's Service Contact Team (CSCT) front door.

Young people asked for;

Transparency

Personalised and accessible services

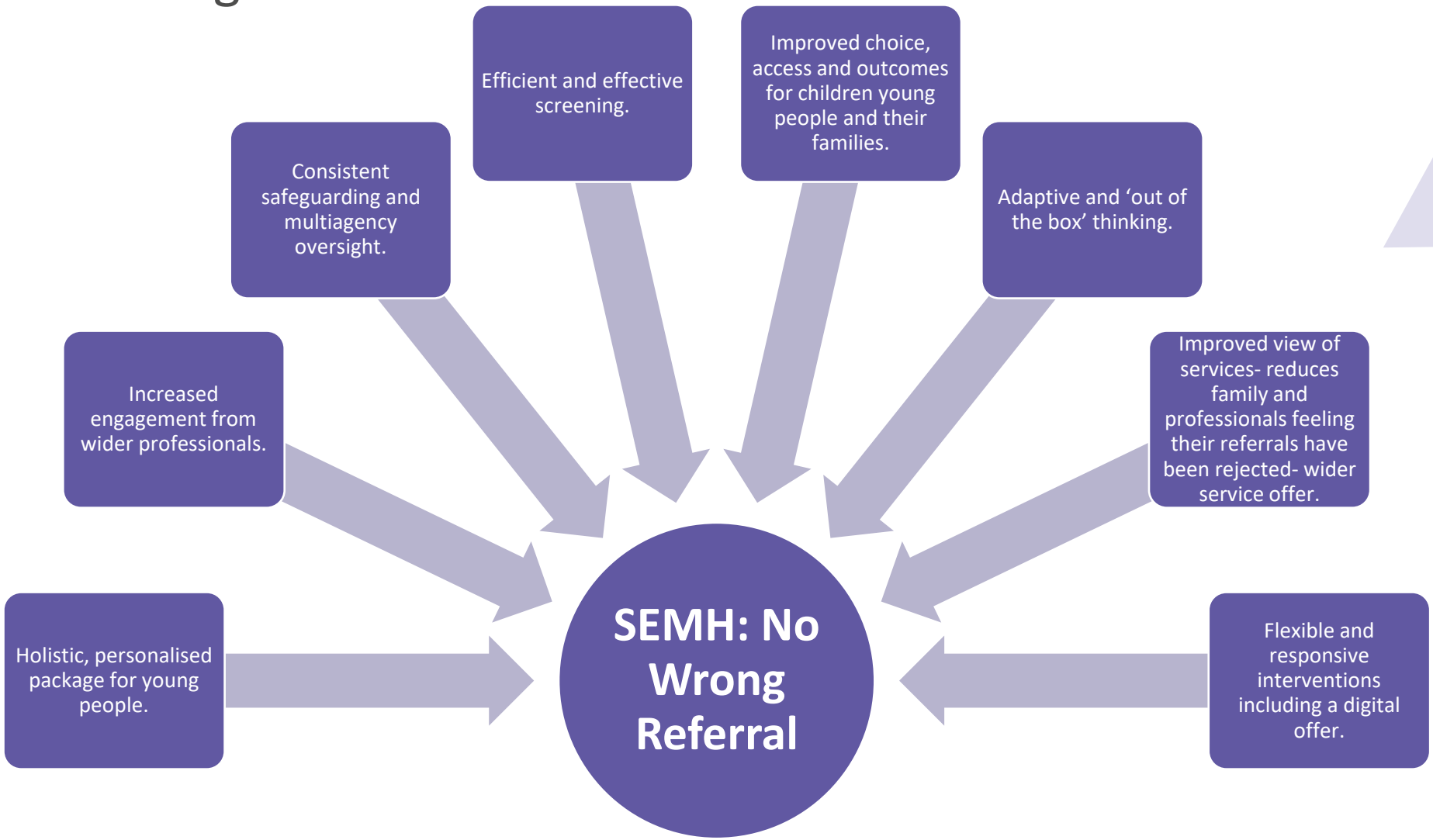
Someone they could trust – Emotional Wellbeing Workers

What was implemented

- An integrated multi-agency central point of access
- No wrong referral model
- Wide range of health and social accessible community services.
- Interventions for short, medium and long-term support.
- An Emotional Wellbeing Service for ages 10-25.
- Digital support: ages 11-25
- Young Adult Support: ages 16-21
- Continuous involvement and evaluation from children and young people.

Social, emotional and mental health (SEMH): No Wrong Referral

North Central London Integrated Care System



"The move to a central SEMH pathway has been transformative from a GP perspective. I think it's been a fantastic service development/redesign. It's simplified the referral pathway, whilst maintaining access to the option to speak to someone for specialist advice if needed. I think it helps to prompt GPs to think more holistically".
Islington Lead GP

Next Steps for Young Adults 16-25 Programme

North Central London Integrated Care System

Phase 1 Jan-March 2023:

- Agree NCL data reporting metrics
- Establish adult governance oversight and reporting streams; to be in addition to the CYP MH Governance
- Continue youth engagement to obtain views on service provision and Youth Board proposal
- Establish NCL ICS Youth Board
- Agree phased 12 month plan to address identified gaps in provision

Phase 2 April 23-March 24:

- Quarterly reporting on agreed data indicators
- Identified areas requiring further investment
- Plans to improve accessibility for identified population cohorts not currently accessing mental health services
- Engagement with universities and colleges to work in partnership to improve support for student health

Phase 3 April 24- March 25:

- Expand on holistic provision of physical and mental health service for young adults including partnership working with ;
  - social prescribing; borough family hubs; the youth justice and violence programme; community groups and physical health services.

Benefits of BEH/C&I mental health strategic partnership

North Central London Integrated Care System

Since 2021, our main providers of mental health services came together in a strategic partnership to collaborate for the benefit of improved outcomes and equity of access for patients. For our residents this has meant…

Allows providers to agree **best use of resources** and implement core services offer	We have been able to collectively agree as an integrated care system (ICS) to investment in early intervention and prevention services at a greater rate than crisis and been able to invest in CYP services to a higher value than any other London ICS. Patients and carers, that we call our experts by experience are able to hold us to account through our revised MH Governance Structure with our NCL ICB CEO chairing this group to ensure mental health is an ICS priority.
Provides opportunity for **clear clinical leadership** and determination of service improvement	There is now 1 MD supported by clinical leads across the trust reviewing clinical models of care. Looking at the best clinical models of care nationally and across NCL, identifying gaps and variation and ensuring the most appropriate clinical model is embedded for that local population
Reduce **unwarranted variation and inequality** in health outcomes, access to services	Reviewed the model of care for the provision of alternatives to A&E and prevention of escalating crisis. NCL have invested £2.5m in (1) Crisis Houses in Barnet, Enfield and Haringey to reduce unwarranted variation compared to crisis houses in the south and (2) Crisis Cafes expanding provision in Barnet, Enfield and Haringey and introducing a crisis café in Camden which didn't have one previously.
Improve **resilience** by, for example, providing mutual aid	BEH and C&I provide mutual aid by sharing inpatient resources where possible to reduce the need to place NCL residents outside of NCL when they require a mental health hospital stay.
Supports data sharing of back office functions between providers	Mental health trusts alongside service users and carers are co-designing an extension to the single point of access telephone line by the end of 2023/24. The 2 crisis lines which manage all patient and professional calls for children and adults will come together and will have additional staff to ensure quicker call standard response times are achieved consistently.

How we promote mental health services and how to access them

North Central London Integrated Care System

As an integrated care system (ICS) we regularly promote information about mental health services and how to access them to NCL residents of all ages through a range of communications channels. These include:

- NCL ICB/ICS, local authority and provider trust **websites,** via service directories and news stories. Plus, NCL GP website and GP Federation sites.
- **E-bulletins and newsletters** to NCL residents, including service updates and mental health awareness campaigns.
- **Social media platforms**, both NCL and local borough, including Twitter, Facebook, Instagram, Nextdoor.
- Patient **information leaflets** – eg, borough Stay Well This Winter leaflets, with signposting info to crisis helpline, NHS Talking Therapies and online support depending on the level of mental health need. Generic NCL version available in easy read format and multiple languages.
- **Service user forums and patient groups**, including specialist groups such as Nubian Users Forum and The Carers' Forum.

We utilize **national and regional campaigns** as a vehicle to amplify messaging about mental health and wellbeing, using this as an opportunity to promote the local service offer. Examples: 'London, you good?', 'Open Your Mind', Healthy London Partnership urgent mental health campaign, aimed at young people.

We work closely with all our partners, including **voluntary** and **community sector,** to maximise opportunities to share info to residents about the mental health support available, particularly recently in conjunction with cost-of-living crisis support.

Key workers and staff in their direct conversations with service users, play a key role in helping to signpost people to a wide range of services to support their mental health needs.

North Central London Integrated Care System

Community Core Offer

How Jack's care will be experienced differently as a result of the Community Core Offer

North Central London Integrated Care System

Child with complex needs

Jack is a British Asian 8-year-old with cerebral palsy. He walks with the support of walking sticks and leg braces. He has difficulties talking and swallowing. He also suffers from moderate learning difficulties and attends a special school. He has regular admissions to hospital suffering from pneumonia. He also has significant hearing loss. His single mother suffers from periodic episodes of depression. They receive support from their extended family

Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers

What care will look like through the core offer

Jack is cared for by an integrated community health team of children's community nurses, a community paediatrician and therapists. He has a case manager who co-ordinates his care and supports the family to navigate his different appointments and wider support available to him. This team regularly reviews Jack's holistic needs getting input via regular multidisciplinary team from his primary care team, school nurses in his special school, the intellectual disability team and his early help social worker.

He has regular physiotherapy and the physio also links in with the orthotics and equipment team to provide support. He has regular support from a speech and language therapist for both his swallowing and his speech. A dietician works with him to ensure that his nutrition is maximised and suitable. An occupational therapist works with Jack and his family and teachers to maximise his independence and also his self-esteem. He has a regular medication review with a community paediatrician. The team links in with the NCL audiology team to ensure that Jack is having reviews for his hearing. Jack has a regular review with the learning disability team who contribute to "Team around the child" discussions. Jack and his family have a dedicated early help social worker who provides support regarding school transport, respite care and also regularly reviews if there are any safeguarding concerns at home. Jack has a regular holistic review of his mental health by a clinical psychologist who is attached to the community health team. His mother receives support from primary care and Improving Access to Psychological Therapies (IAPT) for her depression and is also supported to attend a peer support group for cerebral palsy carers.

In conjunction with the Hospital at Home team, a crisis plan has been developed which enables Jack to be assessed and cared for at home (when appropriate) as an alternative to hospital admissions when he suffers from episodes of pneumonia. This is supported by same day acute paediatric assessment when required from the Rapid access paediatric service.

Resident impacts: CYP Community Services

North Central London Integrated Care System

What are our challenges at the moment?

- **Autism & ADHD:** Significant growth in demand means there are long waiting times across NCL to start autism and ADHD assessments. Capacity is stretched in every borough, but is particularly challenging in Barnet, Enfield and Haringey. Families are not always supported for what to expect from the care pathway – the root cause of complaints. Sometimes getting further support with a child's needs is dependent on getting a diagnosis.
- **Therapies:** There is significant variation in children's therapy offer, resource and waits across NCL with 62% of CYP in Enfield starting assessment within 18 weeks compared with 89% in Camden. Staffing whole time equivalent (WTE) per 10,000 of 0-18 population varies significantly. Access to therapy early intervention support in schools, early years and other universal settings varies. Waiting times are typically longer in boroughs without strong universal offers.
- **Children Looked After (CLA):** There is variation between boroughs in levels of staffing and our ability to ensure that children and young people Looked After have their initial and review health assessment carried out within statutory timescales. In some boroughs, there is insufficient capacity to follow up CLA's health needs between reviews.
- **Children's Community Nursing:** There is variation in children's nursing services, including service offers, capacity and hours of operation. E.g., Barnet and Haringey do not have asthma community nurse posts in place, which may contribute to higher levels of A&E attendances in these boroughs. There is no specialist enuresis offer in parts of Barnet and Haringey. There is limited non-hospice palliative care support in Barnet. Models of continuing care specialist nursing vary between boroughs. A Hospital at Home home-based wraparound nursing support service is only in place for Islington residents at present.

With the Core Offer, what will the service look and feel like?

- **Autism & ADHD:** £1.7m of additional investment will deliver more assessment slots, meaning those waiting longest will be seen more quickly. £600,000 further investment into Barnet, Enfield and Haringey will help make sure that families' needs are met earlier, without being as dependent on an assessment/diagnosis.
- **Therapies:** £700,000 of new Investment into Barnet, Enfield and Haringey will begin to address the variation. Families will start to get more support in early years and mainstream settings to identify delays in and help children's speech, language, communication and motor skills development.
- **Children Looked After:** Investing more than £400, 000 into additional staff within CLA health services in Barnet, Enfield, Haringey and Islington, will mean more CLA receive Initial and Review Health Assessments within statutory timescales and will be able to get more support from health practitioners where health needs are identified.
- **Children's Community Nursing:** New specialists asthma nurses in Barnet and Haringey will support CYP with asthma to better understand and manage their asthma. CYP living in Barnet suffering with enuresis and their families will be supported to access specialist help and children across NCL will get the same care irrespective of where they live. CYP and families in Barnet will have more choice about end-of-life care. More children across NCL will be able to go home from hospital earlier and get follow up care in their own homes.

How Melissa's care will be experienced differently as a result of the Community Core Offer

North Central London Integrated Care System

Working age adult with multiple and complex LTCs

Melissa is a 55 year old Black woman from Kentish Town with poorly controlled Type I diabetes, chronic diabetic foot ulcers. These frequently become infected, and she requires hospital admission for treatment of sepsis.

She suffers from chronic back pain, is obese and has episodes of depression. She has an opioid addiction. She is a teaching assistant at a local school, but frequently has to have time off work. She lives with her partner.

What care will look like through the core offer

Melissa is supported by the community diabetes team who have carried out a holistic assessment of her needs and preferences. A clinician from the team case manages her care bringing together input from the professionals and services involved in her care. A regular multidisciplinary team reviews her care utilising the digital health record. In the past Melissa has chosen not to engage with many NHS services and consequently has had very poor diabetic control with severe vascular complications. However, the involvement of a peer support practitioner from Melissa's local community has greatly helped with improving trust and Melissa's blood sugar control has improved. Melissa was also diagnosed with depression by a psychologist in the diabetes team who has been working with the peer support worker to provide support. Melissa has now agreed to start an anti-depressant which has greatly helped her mood. She had been reluctant to attend the pain management service when it was based at the local hospital, but when instead she was offered a consultation based at her GP practice from the pain management specialist this greatly helped. She is now being supported in conjunction with input from the substance misuse local team to withdraw from her opioids and to switch to alternative pain management medication alongside a pain management course

A community nurse visits Melissa twice weekly to change her foot ulcer dressings with advice from the diabetic and podiatry teams. When these ulcers get infected, the rapid response team is able to provide daily assessment and intravenous antibiotics which has prevented a number of likely hospital admissions.

How Yasmiin's care will be experienced differently as a result of the Community Core Offer

North Central London Integrated Care System

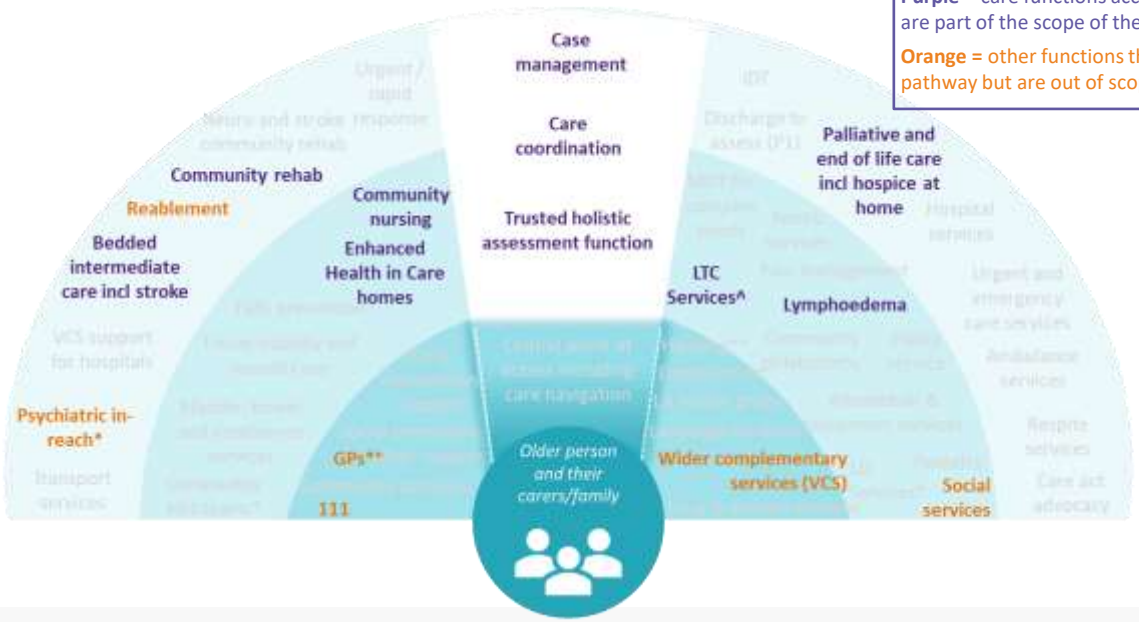
Older adult with palliative care needs

Yasmiin is 87, from Somalia and a long-term resident of Camden but now lives in a Care Home in East Barnet nearer to her family. She has dementia, breast cancer, heart failure and is thought to be in last 6 months of her life.

She has had four hospital admissions in the last six months with breathlessness related to her heart failure

Purple = care functions accessed in the example pathway that are part of the scope of the core offers (community and MH)

Orange = other functions that are accessed in the example pathway but are out of scope of the core offers



What care will look like through the core offer

Yasmiin is reviewed weekly by the enhanced health in care homes (EHCH) team linked to her care home. A GP in the team is her case manager and regularly carries out a holistic assessment of her needs and preferences together with her family. Yasmiin has complex and multiple needs which involve care from a number of members of the EHCH and input from wider services. The end of life care team regularly review Yasmiin and advise the EHCH on symptomatic support for Yasmiin and provide support to Yasmiin's family. They have put together an anticipatory care plan, with co-agreed limits to acute escalation of her care. Community nurses, the geriatrician and a respiratory physio from the EHCH together with end of life nurse specialists support the care home staff to look after Yasmiin when she develops worsening breathlessness from her heart failure and avoid hospital admissions. The community nurse on the team with specialist input from the lymphoedema service manage the complications of Yasmiin's leg lymphoedema. The geriatrician linked to the EHCH team advises the care home team on how best to manage Yasmiin's dementia. These members of the EHCH and wider team meet collectively review Yasmiin's care monthly at multidisciplinary team led by her case manager. Yasmiin's family are supported to access local voluntary sector carer support in the community and Yasmiin is supported to join a music group weekly in the community which she enjoys.

When Yasmiin's condition does deteriorate, the end of life nurse specialist is able to set up a syringe driver in the nursing home and provide bereavement support to her family.

Resident impacts: Adult Community Services

North Central London Integrated Care System

What are our challenges at the moment?

- **Dressing supply service:** This did not exist across NCL and only piloted in Camden and Islington with approximately half the GP practices. There have been incidents relating to patient deteriorations as a direct result of the lengthy process of accessing dressings for housebound patients. This is also very time consuming for all GPs who are currently prescribing these.
- **Ambulatory care service for leg ulcers:** This was never commissioned consistently: Haringey didn't have a service but Islington did, leading to additional costs. Patients who currently have leg ulcers and are ambulatory are not accepted by the community nursing service and are not seen by practice nurses. Practice nurses do not all have the correct skills to see patients with complex leg ulcers.
- **Heart failure virtual ward:** Patients presenting to the Whittington Hospital with acute (decompensated) heart failure are admitted for intravenous diuretic therapy and confirmation of the diagnosis and aetiology by the cardiology team.
- **Specialist Tissue Viability:** A small team of specialist nurses provided specialist advice to Haringey, Islington and Whittington Hospital. They are unable to provide advice to mental health wards at St Anne's and there is a waiting list for specialist advice to practice nursing in Haringey.
- **Community Pain Service:** Isolated secondary care North Middlesex University Hospital (NMUH) Pain team without access to multidisciplinary team approach. Patients require a referral to UCLH to access pain psychology and pain management programme. NMUH Pain consultants then had to refer patients back to GP to access physiotherapy. Disjointed communication between community physiotherapy, GP and NMUH pain team led to suboptimal or delayed care

With the Core Offer, what will the service look and feel like?

- **Dressing supply service:** Dressings will be more accurate and prompt for patients with deliveries within 24 hours. There will be cost savings with reduced waste for dressings and a reduction in time spent by the GPs and practice nurses in writing repeat prescriptions. There will be improved care for the patients with response time reduced from one to two weeks to one to two days.
- **Ambulatory care service:** Leg ulcer clinics for ambulatory patients have been set up to ensure patients get the care they need (e.g. instead of going to the walk in centres). Greater access to leg ulcer clinics across NCL with much closer working with the tissue viability nursing (TVN) service to ensure TVN service can still be used as clinical experts.
- **Heart failure virtual ward:** This will provide safe and excellent care at home for patients admitted with acute heart failure after they have been switched to oral diuretic. Patients will not have to stay in hospital and will be monitored in the community whilst at home, reducing length of stay by 2 days per patient. Patients will still receive the same vital signs and blood tests as if they were in hospital. With a more integrated system, community services are aligned to other services with established integrated pathways for patients.
- **Specialist Tissue Viability:** There will be a more robust service provision to the mental health wards and primary care. Additionally, the service will provide education and policy guidance to community.
- **Community Pain Service:** For patient that has seen the NMUH Pain team they will now have access to a MDT service including physiotherapy, CHP and a pain management programme. There is improved co-ordination of care through MDT meetings reducing duplicate referrals and reducing pain interventional care of limited benefit. A Single point of access via Pain clinics for patients delivering expert consultant opinion in the community.

Proposed financial principles for Community Services investment for 2023/24

North Central London Integrated Care System

The below principles signed-off by the Community Service Review Programme Board in 22/23 have been refreshed:

1. Investment is co-dependent on delivering a proportion of it through **productivity savings** i.e. changing the way services run in order to make them more efficient, including through digital enablers.
2. The **borough gap analysis** should be used to inform decision making, taking into account where we would have greatest system impact on care and on cost;
3. Investment should focus on **historically underfunded areas** and areas where there are persistent and historic inequities;
4. Investment should help to **reduce admissions and improve discharge and elective recovery**;
5. Some investment should be focused on **preventative services**, where there is clinical risk and we should look to enable community services to support **population health improvement** in neighbourhoods;
6. Investment should take into account **capacity to deliver** and deliverability in terms of our workforce, with provider workforce collaboration supported; and
7. Investment should consider how best to support **coordinating functions**, to enable us to respond to the patient and public feedback which has informed our core offer.

Proposed programme key lines of enquiry (KLOEs) used for prioritisation (aligned to design principles)

North Central London Integrated Care System

Strategic fit	• Will this transformation project meet a gap against the full core offer as set out in community service review? • Is it a national 'must do'? • Will this transformation programme support the acute sector either through admission avoidance or by supporting prompt discharge from an inpatient bed? • Will the transformation support population health improvement in neighbourhoods? • Will the transformation support community service workforce development? • Will this transformation contribute to delivering the ICB's financial strategy?
Clinical impact	• Will investment impact positively on clinical care of individual patients? • Will the investment help deliver a performance improvement in admission avoidance, ambulance handovers, A&E attendance or acute hospital flow including reductions in length of stay and discharge and their associated clinical benefits? • Does this service address a clinical gap which has been categorised as causing potential harm/risk to patients?
Health inequalities/ Inequality of access	• Could the development of this service area impact on health inequalities or inequality of access? • Will investment now impact on future delivery in terms of reducing inequalities, impacting on population health outcomes improving access and or contribute to an improved system performance? • Could this investment address historic discrepancies/inconsistences in provision between boroughs and as outlined in core service offer?
Patient experience	• Will service improve patient experience by e.g. reducing waiting times? • Will this service support responding to comments raised by residents/users as part of engagement and co-production? • Will this service contribute to supporting delivering of NCL population health improvement strategy? • Will this service support out of hospital care and supporting people to live in their homes?
Deliverability	• Can we recruit staff • Do we have the management capacity (including clinical leadership) to support this scheme? • Aside from staff are there other investments e.g. capital or IT needed to deliver this service?
System impact	• Does delivery of this scheme provide an opportunity for releasing resources for alternative uses? (resources include staff time, estate and finance, waste and duplication)? • Does investment in this service support transformation through different ways of working including across pathways, the use of digital enablers and contributing to productivity savings? • Does investment impact on system costs and is it affordable ?

What system savings mean for patients and how this creates efficiencies in 23/24

North Central London Integrated Care System

Core Offer	Core Offer identified for potential efficiencies	Investment £'000	Efficiency / ICS benefit	Benefit realisation
Virtual Wards	Virtual wards are part of a well-recognised continuum of 'care at home' models. Through the use of digitally-enabled healthcare, patients are supported with remote monitoring technology to provide care in their own homes for people who would otherwise have been in a hospital bed.	5,411	• >61,000 avoided bed days in 2023/24 • >1000 avoided A&E admissions in 2023/24	System benefits scale with expansion of programme and benefits realisation from Q1 2023/24
Pathway 2 Model Beds	Patients leaving hospital on 'Pathway 2' (P2) will receive rehabilitation with an aim to returning home and will therefore continue to be followed up by the community health teams. The objective is to deliver a high quality, effective and sustainable P2 model across NCL that meets the needs of our residents and our system. P2 provides critical support by enabling NCL residents to have the best rehabilitation and enabling timely discharge from acutes. This project will set the strategy and delivery model for NCL's P2 pathway, (i.e. deliver the core offer) and productivity savings.	n/a	• *In development by provider leads*	Benefits realisation from Q1 2023/24
Tissue Viability	To collaboratively define and implement the core offer for tissue viability nursing (TVN) and the recommend the optimal operating standard for wound care management. This will deliver a consistent service provision with improved wound care outcomes across NCL. This will help reduce burden on urgent and acute care (reduce secondary care utilisation).	n/a	• In 2021/22 a total of 211,141 bed days in NCL hospitals were for patients with leg ulcers	Benefits realisation from Q1 2023/24
Silver Triage	Silver Triage involves real-time support provided by senior clinicians with expertise in geriatric emergency medicine to ambulance clinicians assessing older people (living with frailty) to determine whether a better alternative to hospital conveyance can be found for the patient.	100	• >1,300 avoided bed days in 2023/24 • >190 avoided A&E admissions in 2023/24	Benefits realisation from Q4 2022/23
Enfield Year 1 Interventions	- Community Nursing - 7 day community therapy - Community diabetes capacity	1,950	• >2,300 avoided bed days in 2023/24 • >380 avoided A&E admissions in 2023/24	Benefits realisation from Q1 2023/24
Haringey Year 1 Interventions	- Community Nursing - Community Therapy service - Establishing a pain management service - Boosting support to learning disabilities care homes	1,450	• >500 avoided bed days in 2023/24 • >60 avoided A&E admissions in 2023/24	Benefits realisation from Q1 2023/24
Barnet Year 1 Interventions	- Expanding to a 7 day community therapy model - Community nursing/wound care	425	• >400 avoided bed days in 2023/24 • >60 avoided A&E admissions in 2023/24	Benefits realisation from Q1 2023/24

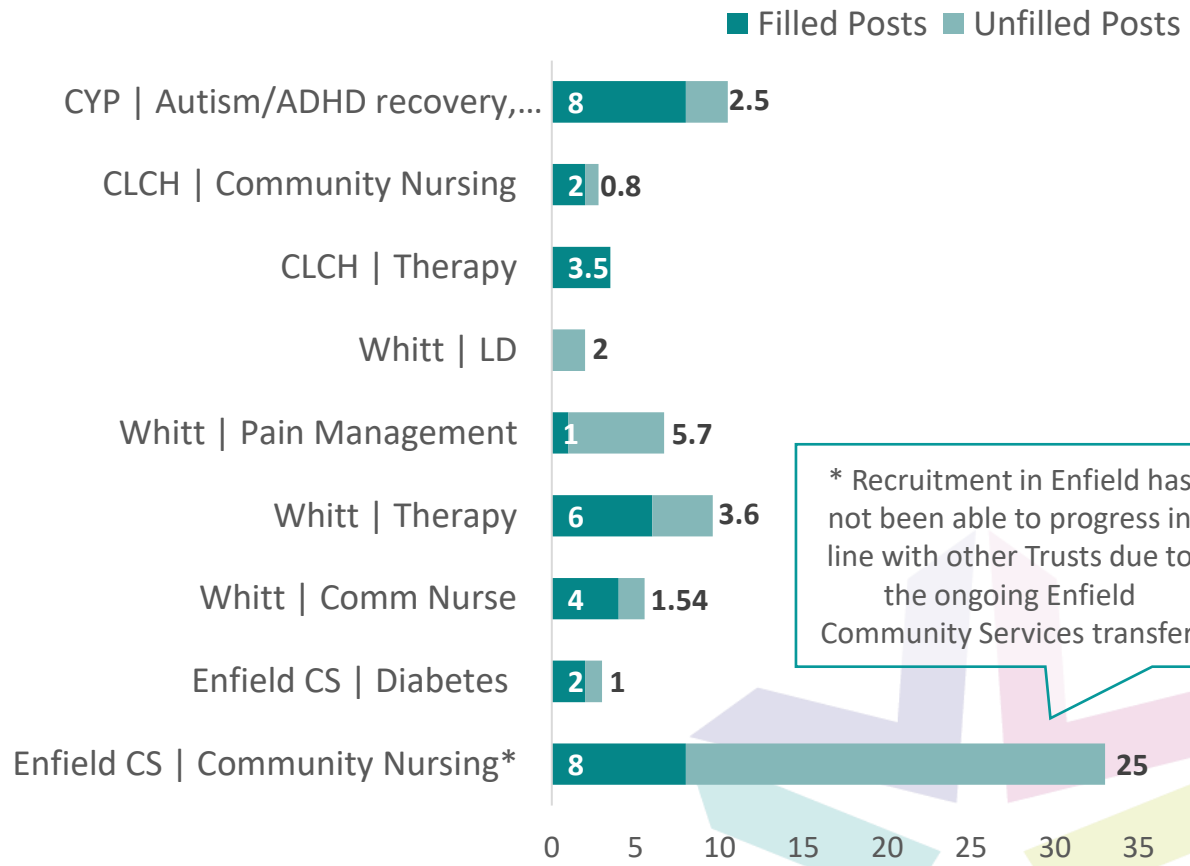
Community Services Review recruitment is progressing through collaboration between providers

North Central London Integrated Care System

Overview and to progress recruitment

- Creating the **North Central London NHS People Strategy** which supports the NHS People Plan
- Investment into an additional **76 whole time equivalent** roles to support the Community 'Core Offer';
- Large scale recruitment exercise commenced in Autumn 2022 and currently underway;
- Excluding Enfield Community services, **66% of new roles now recruited and filled**;
- **Providers working collaboratively** to support recruitment across north central London;
- Collaborative approaches to recruitment including extensive **advertising campaigns, digital marketing, and recruitment open days**.

Community Services Recruitment Sitrep



North Central London Integrated Care System

Concluding remarks

North Central London Integrated Care System

Questions

Does the NCL Joint Health Overview and Scrutiny Committee (JHOSC) have any recommendations for how we can **expand and deepen our approach to co-design** and development?

Are there any Borough patient representatives who would be willing to contribute to the priority setting exercise for investment in 23/24 at the **Borough Priority Setting workshops in February**?

Does the JHOSC have any **questions relating to the core offer?**

What information would the JHOSC like to see at the **next presentation**?

North Central London Integrated Care System

Appendix

The following slide shows the segmentation of borough and NCL delivery areas within the community “core offer”

NCL deliverables	DELIVERY AREA	Borough deliverables
• Consistent model of care blueprint aligned to NHSE requirements; Consistent KPIs and coordination of monitoring for AC, UCR, and EHCH; Consistent approach to pop segmentation infrastructure • Common model for Silver Triage led by collaborative (hosted by CNWL)	**Ageing Well (UCR, EHCH, AC)**	• Multi-agency implementation of AC work and place workforce managing benefits realisation and improvement via ICP-based governance inc AEDB (2 hr responses, conveyances reductions, % of care plans within target cohorts completed)
• Common pathway for LTCs (Diabetes, Heart failure) in line with NCL prioritisation and proactive care LTC networks that CHS plug into • Common model for structured diabetes education (inc digital enabler) and other diabetes functions(e.g. spec nursing and podiatry input)	**Joint work on LTCs in neighbourhoods** Part of proactive care work programme	• Implementation of NCL LTC models in neighbourhood in collaboration with patients, community, primary care, mental health, VCS and local authority
• Hospital @ Home • Therapies accelerator • Autism hub • Provider led reviews	**CYP**	• Looked after children • Enuresis (Barnet) • Asthma
• Common model/SOP across ICS to be managed as provider collaborative • Single digital platform to monitor patients; Benefits realisation tracking	**Virtual Wards**	• Effective local operationalisation between CHS/Acute/LA/VCS/PC • Ensuring capacity is optimised and reductions in acute demand for beds
• Consistent model in line with ‘core offer’ across ICS through collab. work • Agree roles/responsibilities & SOP across ICS for CH and PC for TV	**Tissue Viability**	• Implementation of standard operating procedure between primary care and community to be managed at local level
• Common model for NHS provider beds in line with ‘Core Offer’ and consistent SOP to be managed by provider collaborative • NCL programme to reduce LOS and variability in offer between NHS units, right-sizing provision; ICE Hub coordination of access into P2 units	**P2 Beds**	• Joint work re. optimising use of Care Home based P2 beds (Mildmay, PWH, St Anne’s)
• NCL ISG sign-off of delivery plans • Report to NCL ISG re. implementation progress and benefits realisation	**CSR Y1 investments**	• Provider-led implementation at place; Providers to report on benefits realisation associated with investment, and progress on ensuring ‘core offer’ in place in line with investment into place-based fora
• Benefits realisation reporting and progress against project/prog milestones liaising with place/NCL wide collaboration work as required including regarding risks/ mitigations • Liaison with NCL wide and place based initiatives re. highlight reporting • Management of programme board and Implementation Steering Group	**PMO**	• Coordinating integration plans and reporting of delivery (milestones and KPIs) into place based governance forums re. implementing “core offer” • Provision of highlight reports; milestone progress, risk and mitigations from place into NCL wide governance via NCL PMO team
• Leadership on core programme narrative, JHOSC updates as well as cross-NCL change material/narrative	**Engagement**	• Leadership of engagement forum inc. HWBB updates re. local implementation by providers/DOIs/local commissioning leads with support from programme team re. core programme narrative

The following slide shows the segmentation of borough and NCL delivery areas within the mental health "core offer"

NCL deliverables	DELIVERY AREA	Borough deliverables
• Home Treatment • Dialectical Behavioural Therapy • Tier 4 Provider Collaborative • Crisis pathway • Eating Disorders (Intensive Service, Home Treatment)	**CYP**	• CAMHs / Community / THRIVE implementation; autism spectrum disorder / ADHD pathways; Early intervention and prevention • *Integrated Targeted Services**; Looked after children; CYP MH in Schools / Support Teams • Young Adults 16-25
• Workforce • Digital • Perinatal • NDD	**Mental Health Programmes**	• Borough specific projects (e.g. Barnet Ken Porter Ward), Rough sleeping, suicide • Bereavement care; Dementia; *Co-production**, *Quality**, • *Health inequalities**; *Early intervention and prevention**
• Out of area placements • Length of stay • Quality • Winter schemes	**Inpatients**	• Integrated discharge teams and flow into Local Authority placements
• NCL digital • HLP system maturity tool • Group sessions / publicity • Staff health and well-being hub	**IAPT**	• GP referrals • *Long term conditions development pathways / Covid recovery** • VCS offer • Specific Health Inequalities outreach programme
• Crisis lines / Think 111 / Single point of access • MH Joint Response Car • MH Liaison Services	**Crisis**	• Crisis cafes • Crisis houses
• NCL Severe Mental Illness (SMI) Physical Health Clinical Network • Overarching Framework for Community Transformation 1. Personality Disorder 2. Rehab 3. Comm Eating Disorders 4. EIP 5.*Older/Young adults**	**Community**	• Severe mental illness health checks • Individual Placement Support • Borough co-production and implementation of Community Transformation Prog
• Benefits realisation reporting and progress against project/prog milestones liaising with place/NCL wide collaboration work as required including regarding risks/ mitigations • Liaison with NCL wide and place based initiatives re. highlight reporting • Management of programme board and Implementation Steering Group	**PMO**	• Coordinating integration plans and reporting of delivery (milestones and key performance indicators) into place based governance forums re. implementing "core offer" • Provision of highlight reports; milestone progress, risk and mitigations from place into NCL wide governance via NCL Programme Management Office team
• Leadership on core programme narrative, JHOSC updates as well as cross-NCL change material/narrative	**Engagement**	• Leadership of engagement forum inc. Health & Wellbeing Board updates re. local implementation by providers / Directors of Integration /local commissioning leads with support from programme team re. core programme narrative

** Delivered at both NCL and Borough*

Our approach to investment to fund the core offers

North Central London Integrated Care System

The case for change for community and mental health services

- The case for change highlights that there is **significant variation in spent per head** in different boroughs and this does not correlate with need, and that the boroughs with a lower proportion of spend on community health services tend to have a **higher proportion of spend on acute services.**
- The 'do nothing' scenario will result in an **increased acuity of patients** not receiving effective out of hospital care and increased acute costs in the long term, **increasing overall system deficit**.

Investment as an enabler of the Core Offers

- **Investment is required** to reduce system cost and **relieve pressure on our acute hospitals through** reduced urgent care activity, improving system sustainability in the long term.
- Investment will also support providers to **unlock productivity improvement initiatives** through initial investment via closer collaboration and transforming care delivery.
- Investment will also seek to **address historic inequities in funding** to improve outcomes and financial sustainability in boroughs that have received funding below their level of need.

Investment profiling

- The **mental health funding plan** sets out affordability using the Mental Health Investment Standard (MHIS) and System Development Funding (SDF). This reflects the strong alignment between delivery of the mental health core offer programme and mental health NHS Long Term Plan. The phasing requires the mental health system to work together and identify productivity and efficiency savings to support core offer investment plans as MHIS/SDF funding on its own is insufficient.
- **Community profiling is over a 5 year period** rather than a 3 year period due to feasibility of delivery. The step change in to Year 2 (2023/24) in this model is more realistic in both planning and delivery terms. Initial Year 1 funding has been provided in order to start to enable some of the highest priority gaps to be tackled to enable productivity and system savings initiatives that will benefit from Year 2.

Delivering productivity and system savings

- **Financial planning and delivery of the savings will be the responsibility of providers**. Providers have signed up to a number of collaboration priorities between themselves and acute providers (e.g. Pathway 2 beds transformation and mental health crisis transformation respectively) to reduce system cost and increase productivity.
- Significant savings will be achieved through **investment and transformation planned** by providers, including Virtual Wards, Silverline (phone triage service for care homes) and and mental health crisis support.
- The programme has agreed the **lower range of productivity and system savings** modelling to ensure deliverability.